Florida's TANF SAMH Program
Service Planning/Tracking Form

Florida has developed a set of forms to track outreach activities, the number of screenings and referrals, and the number of clients accessing treatment. These forms, listed below, are completed by the TANF SAMH contracted service providers and submitted to the TANF SAMH specialist:

- **TANF SAMH Screening and Referral Analysis Form.** This form, submitted by contracted service providers to the TANF SAMH specialist at the end of each month, reports on the number of clients referred for different reasons (e.g., substance abuse referrals, domestic violence referrals, outreach contacts made that month, etc.).
- **Log of Outreach Activities Form.** This form is a monthly reporting form completed by the contracted service provider. Types of services, total units of services, and number of persons served are some of the data reported on this form.
- **SAMH Treatment Verification Form.** This form was developed to approve time limit extensions for clients successfully completing treatment. TANF SAMH treatment providers indicate the amount of time a participant has spent in treatment. This information is used to determine whether a time limit extension should be granted for the number of months spent in treatment.
- **TANF SAMH Client Log.** The client log is used to track individual client information such as name, social security number, TANF participant status, and status date.

TANF SAMH Screening & Referral Analysis

Month _____, 2000

TANF SAMH Provider: _____ Screener: _____ Date Completed:_____

Please place a tally mark next to the appropriate items and total at the end of the month.

Number of:	**At the One-Stop**	**Other Locations**
TCA applicants/recipients screened	_____	_____
TDF diversion population screened	_____	_____
Screening refused	_____	_____
TCA applicants/recipients referred for assessment from screening	_____	_____
TDF diversion population referred for assessment from screening	_____	_____
Other referral indicators (i.e. obvious intoxication, flight of ideas)	_____	_____
Referrals upon request for self	_____	_____
Referrals upon request for family member	_____	_____
Referrals for assessments made by the RWB designee	_____	_____
Substance Abuse referrals	_____	_____
Mental Health referrals	_____	_____
Domestic Violence referrals	_____	_____
Emergency referrals	_____	_____
Days on average from referral to assessment	_____	_____
Referrals not getting assessments	_____	_____
TCA applicants/recipients attended orientation	_____	_____
Outreach contacts made this month	_____	_____
TANF participants that entered treatment this month	_____	_____

Temporary Assistance for Needy Families

Log of Outreach Activities

Agency Providing Service: ____________________________ **Vendor I.D Number:** ___________

Billing Period: ____________ **Total Units of Service:** ________________

Service Date	Staff Name and ID Number	Service Site	Type of Service	Total Units of Service	Number of Persons Served	Agency Receiving Referral

Substance Abuse and Mental Health (SAMH) Treatment Verification

CONFIDENTIAL SENSITIVE INFORMATION - MUST BE KEPT LOCKED WHEN NOT IN USE.

Section A:

_____ _____ ____/____/____

Participant Name Social Security Number Date

_____ _____

Regional Workforce Board (RWB) Designee Public Assistance Specialist (PAS)

RWB/PAS Address: _____ RWB/PAS Region _____

_____ RWB/PAS Fax #: _____

_____ _____ _____

SAMH Provider Agency Telephone Number Fax Number

Section B: ***Limited Work Exception for Non-Medical Incapacity Treatment Verification***

The participant above is currently participating in a treatment program. The participant has completed ____ hours of treatment during the past month, for the following weeks:

Week 1: ____/____/____ - ____/____/____ for _____ hours. Week 2: ____/____/____ - ____/____/____ for _____ hours.

Week 3: ____/____/____ - ____/____/____ for _____ hours. Week 4: ____/____/____ - ____/____/____ for _____ hours.

The participant's total hours of completion in the treatment program during the past 12 months are _____ hours.

_____ _____ ____/____/____

Name and Credentials of SAMH Counselor/Case Manager Telephone Number Date

Section C: ***Completion of Treatment Verification***

The participant indicated above has successfully completed a Mental Health / Substance Abuse Treatment Program. The months in which the participant fully complied with the treatment requirements are circled below, totaling ____ months in a(n) _____ program.

20____: January February March April May June July August September October November December

20____: January February March April May June July August September October November December

_____ _____ ____/____/____

Name and Credentials of SAMH Counselor/Case Manager Telephone Number Date

Section D: ***Public Assistance Specialist Verification of Treatment Months and Receipt of Temporary Cash Assistance***

The number of months verified and approved for an extension to the participant's time limit are _____ months.

_____ _____ ____/____/____

Public Assistance Specialist Telephone Number Date

Section E: ***Understanding Extension Treatment Months***

I understand that my time limit has been extended _____ months due to my completion of the SAMH treatment program.

_____ ____/____/____

Participant Signature Date

_____ _____ ____/____/____

Regional Workforce Board Designee Telephone Number Date

Comments: _____

_____

For Official Use: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and Chapters 394 and 397, Florida Statutes. The federal and state rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2 and Chapters 394 and 397, F.S. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal; and state rules restrict any use of the information to criminally investigate or prosecute any substance abuse/mental health participant.

CF-ES 2299, OCT 00

TANF SAMH Service Provider
Client Log

Provider's Name: _____ Vendor I.D. Number: _____

Address: _____ Date: ____/____/____

_____ District: _____

TANF SAMH Participant Name			Social Security Number	TANF Participant Status*	Status Date
LAST	FIRST	MI			
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

* I am attesting, by my signature, that the TDF participants on this Client Log still meet the TANF Income eligibility requirements for this month according to the 200% of Federal Poverty level guidelines provided.

Provider Signature: _____ Date: ____/____/____

TANF Participant Status	**1** = TCA (applicant/recipient/Post-TANF)	**2** = TDF
3 = Successful D/C	**4** = Administrative D/C	**5** = No longer eligible for TANF SAMH Services